

PRE-APPLICATION FOR ENROLLMENT – HEAD START

Return To:

Indianhead Community Action Agency – Head Start
209 East 3rd Street South
P.O. Box 40
Ladysmith, WI 54848 -1839
Phone: (715) 532-5594
Fax: (715) 532-5804

OFFICE USE ONLY:
 Program: _____
 IE OI REF _____
 ENR Letter Sent: _____
 Currently Enrolled YES NO
 _____ New _____ Repeat _____ Referral

Head Start is a federally funded program serving low-income families and children 3 – 5 years old. Services are provided in the counties of Burnett, Clark, Rusk, Sawyer, Taylor, and Washburn. The information below is necessary for our records and will be kept confidential.

The information must be **COMPLETE AND ACCURATE**. Please use **INK**.

Please list the name(s) of the child(ren) enrolling in Head Start:

Child's Name: _____ / _____ / _____ M___ F___
FIRST LAST DATE OF BIRTH SOCIAL SECURITY #

Directions to Home: _____

Father/Legal Guardian: _____ / _____ / _____ SOCIAL SECURITY # _____ CURRENT OCCUPATION _____
FIRST LAST DATE OF BIRTH SOCIAL SECURITY # CURRENT OCCUPATION

Mother/Legal Guardian: _____ / _____ / _____ SOCIAL SECURITY # _____ CURRENT OCCUPATION _____
FIRST LAST DATE OF BIRTH SOCIAL SECURITY # CURRENT OCCUPATION
 ___ Married ___ Divorced ___ Separated ___ Single ___ Unmarried - Living Together

Mailing Address: _____ - _____ - _____ TELEPHONE # _____
STREET / ROUTE CITY STATE ZIP CODE TELEPHONE #
 COUNTY SCHOOL DISTRICT CELL PHONE #

Non-shared Custodial _____ - _____ - _____ TELEPHONE # _____
Circle One STREET / ROUTE CITY STATE ZIP CODE TELEPHONE #

Please list one (1) additional name and telephone number for someone we may call to leave a message or contact you.
 NAME: _____ TELEPHONE # _____

Total immediate family members in household (including child(ren) listed above): Adults ___ Children ___ Ages of Children _____

Are you able to transport your child? (Circle one) YES NO

Are there any concerns about your child(ren) or family you would like us to know? (I.e. Health, Disability)

Child has been referred to Head Start by: _____
NAME TITLE / AGENCY

Do Parents Speak: ___ English ___ Spanish ___ Other Do the child(ren) Speak: ___ English ___ Spanish ___ Other

INCOME VERIFICATION (PROCESSING WILL BE DELAYED IF NOT COMPLETED)

It is required that the Head Start office have proof of income for families of all HEAD START children. Proof of 12 months income **MUST** be attached. Application will not be processed until proof of income is received.

INCOME SOURCE	GROSS INCOME PER MONTH	# MONTHS RECEIVED	TOTAL FOR 12 MONTHS
Employment			
Employment			
Other (please check) <input type="checkbox"/> Wisconsin Works W2 <input type="checkbox"/> Foster Care <input type="checkbox"/> Child Support/Alimony <input type="checkbox"/> SSI <input type="checkbox"/> Unemployment <input type="checkbox"/> Other			

I hereby certify that I have completed this application truthfully and correctly. I also give permission for Indianhead CAA-Head Start to verify this information with any necessary sources.

Parent / Legal Guardian Signature: _____ Date: _____

